VOL. 3, No. 1 JANUARY 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

TOWARDS NEW INTERNATIONAL SANITARY REGULATIONS

MALARIA IN EUROPE

INFLUENZA IN EUROPE

EASTERN MEDITERRANEAN CONFERENCE

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VOL. 3, No. 1 JANUARY 1949

CHRONICLE OF THE WORLD HEALTH ORGANIZATION

TOWARDS NEW INTERNATIONAL SANITARY REGULATIONS

First session of the Expert Committee on International Epidemiology and Quarantine

International health regulations will be needed until the true objective of international epidemic control — the eradication of pestilential diseases — has been achieved. This emerged clearly from discussions held during the first session of the Expert Committee on International Epidemiology and Quarantine, entrusted by the first Health Assembly with the study of the best means of relieving public-health administrations from the constant menace of epidemic outbreaks of smallpox and typhus, and, over large areas of the world, of cholera, plague and yellow fever.

The present expert committee continues the work of two expert committees of the Interim Commission — the Expert Committee on International Epidemic Control and the Expert Committee on Quarantine. The former committee, which had met in Geneva in April 1948, had agreed, among many other things, that " protective measures taken by countries at their respective borders under existing international sanitary conventions were palliatives, as effective international control of epidemics required delimitation of endemic areas " and recommended " an attack on the endemic foci with the technical help of WHO, if needed ." [1]

The new committee,[2] some members of which had already served on the two committees of the Interim Commission, met in Geneva from

[1] *Off. Rec. World Hlth Org.* 11, 21; see also *Chron. World Hlth Org.* 1948, 2, 145

[2] Present at this session :
Professeur A. R. Dujarric de la Rivière, Sous-Directeur de l'Institut Pasteur, Paris, France
Dr. G. L. Dunnahoo, Medical Director, Chief, Foreign Quarantine Division, US Public Health Service Washington, D.C. USA
Dr. H. S. Gear, Deputy Chief Health Officer for the Union of South Africa, Cape Town, Union of South Africa
Dr. G. D. Hemmes, Inspector of Public Health, Utrecht, Netherlands [*Continued on p. 2*]

15–20 November 1948. Having unanimously agreed that defensive measures against pestilential diseases will still be needed for some time, the committee set as its main task the definition of the principles on which WHO sanitary regulations should be established. It will be recalled [3] that these are intended to replace the present international sanitary conventions, which are held to be awkward and obsolete in many respects.

Basic Principles

The committee agreed that it was desirable that the regulations should be prefaced by a preamble showing the respective responsibilities of governments and of WHO in the international control of epidemic diseases. Dr. Dujarric de la Rivière was entrusted with the task of writing the preamble, together with a commentary on the proposed principles.

The preamble would outline the essential principles on which the actual articles of the regulations had been based; and in particular emphasize that :

(*a*) accurate and rapid notifications were the basis of effective measures against the international spread of disease and of the withdrawal of restrictions on international traffic as soon as danger of infection had ceased;

(*b*) each country should develop its internal resistance to disease, rather than rely on measures taken at its frontiers. For instance, proper sanitation, country-wide immunization and freedom from insect vectors would effectively prevent epidemics of cholera, smallpox, typhus fever etc., should such infections be introduced through evasion of the frontier quarantine control;

(*c*) measures taken at frontiers should be the minimum compatible with the existing sanitary situation. Excessive measures not only entailed undue interference with traffic and severe economic consequences, but might, by their very excess, lead to deliberate evasion of the sanitary control and thereby defeat their object. The committee emphasized the principle that the measures to be specified in the WHO regulations should not be exceeded by health administrations. It would therefore be necessary to specify the maximum measures applicable in exceptional as well as in normal circumstances.

Dr. Melville Mackenzie, Principal Medical Officer, Ministry of Health, London, United Kingdom
Dr. C. Mani, Deputy Director-General of Health Services, New Delhi, India
Dr. M. Nazif Bey, Under-Secretary of State for Quarantine, Ministry of Public Health, Cairo, Egypt
Professor G. H. de Paula Souza, Director, Faculty of Hygiene and Public Health, University of São Paulo, Brazil
Dr. W. W. Yung, Chief Medical Officer, Ministry of Health, Nanking, China

Ex officio members:

Dr. M. Gaud, Rapporteur of the Joint OIHP/WHO Study-Groups
Dr. A. M. Macchiavello, representing the Director of the Pan American Sanitary Bureau
Dr. M. T. Morgan, Président du Comité permanent de l'Office International d'Hygiène Publique
Dr. F. E. de Tavel, representing the International Civil Aviation Organization.

Secretariat:

Dr. Y. M. Biraud, Director, Division of Epidemiology, WHO, Secretary of the Committee
Dr. G. Stuart, Chief, Sanitary Conventions and Quarantine Section, WHO.

[3] *Chron. World Hlth Org.* 1947, 1, 122

Epidemiological Notification and Information

The system of present and future defence against epidemics rests on prompt information of any outbreak, and the committee stressed the need for every country to send immediate notification to the nearest WHO regional epidemiological information station and to the WHO world centre and, when possible, to neighbouring countries.

This is not enough, however, as increased speed of traffic necessitates an increased speed of epidemiological information. The committee therefore approved a proposal made by the Secretariat to initiate, on an experimental basis, a daily radio-telegraphic broadcast of an epidemiological bulletin by WHO at Geneva, thus extending a system which had proved its practical value in the zone served by the Singapore Epidemiological Station. The radio bulletin would include information about pestilential diseases in sea- and airports, as well as new quarantine and immunization requirements. The bulletins, consisting of 200 to 300 words, would be broadcast on long-wave to cover Europe and on short-wave, in three beams, to cover the other continents. National health-administrations would give instructions to the telegraphic authorities in their countries to pick up the bulletins and distribute them by multiple-address telegrams to selected port and sanitary authorities. This would ensure cheap, rapid and effective dissemination of the epidemiological information collected.

The establishment of this new system need not, it was decided, await the coming-into-force of the new regulations, but could be applied forthwith as an experimental measure, concurrently with the system of notification now in force.

Definition of "Local Areas" as a Basis for Notifications and Measures

Notifications should be made only in respect of, and measures should be taken solely against, arrivals from distinct units (administrative or sanitary) which could be described as "local areas".[4] Only when no definition of the infected area is available should restrictive measures be applied against the whole national territory.

Identification of infected local areas will be facilitated by the list of administrative districts of the various countries which will be included in the new epidemiological code now being prepared by the WHO Secretariat (*Codepid*) and grid maps for localization of infection within provinces and districts.

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[4] According to the definition contained in the first chapter (Article 8) of the International Sanitary Convention, 1903, which provides that "the words 'local area' denote a well-defined area, such as a province, a government, a district, a department, a canton, an island, a commune, a town, a quarter of a town, a village, a port, a polder, an agglomeration etc., whatever may be the extent and population of such areas."

Adaptation of Measures to Degree of Infection

The rule provided by the present conventions [5] that measures should not be taken against sea- or airports in which only imported cases had occurred, will continue in the new international regulations.

The following degrees of infection should be recognized in the WHO regulations: (*a*) an initial case; (*b*) a "foyer"; (*c*) an epidemic. A "foyer" is characterized by the occurrence of secondary cases around an initial case, an epidemic by an extension and/or multiplication of the "foyer".

International sanitary measures permissible against an infected local area should depend upon the degree of infection and upon the efficacy of the control measures applied to the outbreak by the health authorities of the infected country. Such efficacy could be judged objectively only on the basis of prompt and accurate notification from the infected local area as to the number and distribution of cases, showing the development or regression of the outbreak.

Cessation of Danger of Infection

One of the recognized shortcomings of the present international sanitary conventions is that judgement on the cessation of danger of infection is left with the sanitary authorities of the infected area. While it is universally agreed that measures should not be taken against an infected area or country longer than the danger of transmission persists, there is seldom unanimity on the duration of the danger.

An attempt will be made in the new regulations to overcome this difficulty, and it was proposed that a country should be given the right to notify the cessation of danger when preventive measures had been carried out without interruption, intensively and successfully, and in addition, a period of x days had elapsed, counted from the date of isolation, death or recovery of the last case.

It was agreed that the period of x days should be based on the period of incubation of the disease, plus a period of security, intended to cover possible delay in diagnosing a case and the lag between the recognition and notification of the said cases. (The security period might, for instance, be equal to twice the period of incubation.)

It is important to note that cessation of danger of infection could only be notified at the end of an epidemic in an area normally free from infection, but not in an area where disease remained endemic and where, in consequence, danger of infection persisted.

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[5] Article 10, International Sanitary Convention, 1926, amended by the International Sanitary Convention, 1944

Can this new definition be expected to put an end to the controversies which have arisen, under the present conventions, among the various health administrations? While it may reasonably be hoped that in most cases there will be general agreement, the possibility of occasional divergencies of opinion will still exist, and the committee deemed it necessary to investigate means of arbitration.

The first Health Assembly had already decided that WHO experts could act as arbitrators after a visit on the spot: such arbitration could take place if a country complained that another country continued to impose restrictive measures against it and therefore invited WHO to send an expert observer to the area in question. It was believed that infected countries would realize the advantages to be gained from the presence of such an observer: it would help greatly in allaying unfounded fears concerning the epidemic situation, thus preventing excessive measures from being taken by other countries, and enabling WHO to announce, without unnecessary delay, the cessation of danger of infection.

The committee agreed, however, that no mention of observers should be included in WHO sanitary regulations, and stressed that at present only moral pressure could be applied to persuade countries to give up sanitary measures exceeding the provisions of the sanitary conventions, but suggested that such cases might be brought formally to the attention of the Health Assembly.

Adaptation of Measures to Degree of Susceptibility of Countries to Infection

Another notable improvement on the present conventions was the proposal that countries should be encouraged to reduce, or even suppress, measures against the importation of certain diseases when their territory was not infectible owing to absence of insect vectors, immunization of the entire population etc. This follows naturally from the now generally recognized principle that the national health-administrations should develop their state of defence against epidemic diseases rather than rely on restrictive measures at their borders or on measures taken by other countries.

Immunization and Immunization Certificate Requirements

The medical profession cannot have failed to note that there has developed since the last war a widespread tendency, on the part of governments, to require from travellers certificates of immunization, irrespective of the value of such immunization for the protection of the countries reached by travellers or for that of travellers themselves. The expert committee was aware of the many disadvantages inherent in the compulsory production of immunization certificates, and considered that the serious obstruction to free and rapid travel caused by such requirement was out of proportion

to the protection likely to be afforded to the country of arrival. It was therefore decided that certificates of immunization against plague and against typhus should not be required from travellers, even if coming from areas infected with those diseases. This represents another notable simplification, as certificates of immunization against typhus are specifically recommended under the present conventions, and as certificates of immunization against plague are often requested by certain countries although there is no provision to that effect in the conventions.

As to the inoculations against cholera, the committee decided that, while being of value to the individual for his protection in an infected area, they have comparatively little value as a quarantine measure to prevent the entry of the disease into a cholera-free country. It was accordingly agreed that WHO regulations should not oblige countries ordinarily to require incoming travellers to submit to inoculation against cholera or to produce anti-cholera inoculation certificates. Regulations should, however, make it permissible for countries to require such certificates from travellers coming from infected local areas. It is interesting to note that, in the opinion of experts, there were reasons to believe that immunity induced by cholera inoculation lasted at least six months, and that there were experimental indications that even greater protection might be expected from Sokhey's vaccine now in the course of field-trial.

Measures relating to Merchandise and Baggage

Merchandise coming from an infected area should not be subjected to sanitary measures, as already provided by the present conventions, unless exposed to infection and suspected of being contaminated by infectious material or of harbouring reservoirs or vectors of disease. With regard to cholera, it was agreed that contamination had to be of recent date to constitute a danger.

The committee considered that further study should be made to determine whether a special chapter of WHO sanitary regulations should eventually be drafted to cover measures, now left with each government, applicable to merchandise, for the prevention of non-pestilential diseases such as anthrax, psittacosis, etc.

Veterinary authorities will be consulted to decide whether WHO regulations should cover the sanitary requirements of transport of live animals capable of harbouring or of transmitting diseases communicable to man (rabies, psittacosis, brucellosis, tuberculosis, Q fever, etc.). This represents another innovation in the sanitary regulations.

Finally, it was agreed that the personal baggage of travellers should not be subjected to sanitary measures, unless the traveller himself was suffering from one of the pestilential diseases or infested with vectors of such diseases. No sanitary measures should be applied to mail. The same

exemption should normally be extended to parcel post, provided it did not contain articles likely to be contaminated, such articles to be specified in the case of each epidemic disease.

Transit Passengers at Airports

An attempt was made to alleviate quarantine measures in this respect, which are known to have hampered to some extent in the past the international system of air travel. Thus, the expert committee agreed that no restrictive sanitary measures or immunization requirements were to be applied to passengers in transit at an airport, provided they were not suffering from a communicable disease and did not leave the precincts of the airport. This measure, if accepted, would represent a significant departure from the letter of the present conventions.

Disinsectization of Aircraft

Disinsectization of aircraft is prescribed by the present conventions, but a selection of the methods and insecticides to be used is left entirely with the governments concerned. Continuance of such freedom was deemed unwise by the expert committee now that extensive knowledge had been gained on DDT and other similar insecticides, and it was decided that methods and insecticides to be used for the disinsectization of aircraft engaged in international traffic should be prescribed in WHO regulations.

Drafting of New Regulations

It will be seen that the expert committee was guided in its work by a desire to alleviate and simplify the quarantine restrictions to the farthest possible extent compatible with the security which must be ensured to every country. The preamble to and commentary on the basic principles, prepared by Dr. Dujarric de la Rivière, will be submitted by correspondence to the members of the expert committee for amendments and observations. The text incorporating such amendments will then be submitted to the Executive Board and, if approved, to the Health Assembly. The approval of those principles by the Assembly would make it possible for the Secretariat to draw up the actual draft text of WHO regulations. This draft text would be discussed again by the committee at a later session and as modified would be submitted to governments prior to its final adoption by the Health Assembly.

Meeting of the Quarantine Section of the Expert Committee

The expert committee appointed as members of its Section on Quarantine Dr. Dunnahoo, Dr. Gear, Dr. Mackenzie, Dr. Nazif Bey, and Dr. Yung, together with Dr. Morgan as ex officio member. The powers entrusted to

the committee by the Executive Board as regards the interpretation and administration of existing sanitary conventions were delegated to this section. The expert committee informed the quarantine section that according to the type of infringement of existing conventions, cases would be dealt with : (*a*) by the Secretariat, acting on its own initiative and keeping a look-out for such infringements; (*b*) by correspondence between the Secretariat and the members of the Section on Quarantine; (*c*) by the Section on Quarantine in session; (*d*) by the expert committee itself in plenary session.

The Section on Quarantine met on 18 November, and discussed, among other things, complaints by the Government of India against other countries imposing measures in excess of the sanitary conventions; the fumigation of ships with loaded holds; the period of validity of certificates of immunization against smallpox, cholera and yellow fever; the authentication of certificates; and the time required for the development of effective immunity following inoculation with yellow-fever vaccine. The report of the expert committee and of the quarantine section will be published in a forthcoming volume of the *Official Records of the World Health Organization.*

MALARIA IN EUROPE, 1938-1947

The incidence of malaria, like that of other infectious diseases,[1] has undergone a great change as a result of the war. Dr. E. J. Pampana draws attention to this fact in an article which has just been published in the *Epidemiological and Vital Statistics Report* (Vol. 1, No. 18, p. 392). The principal factors contributing to the spread of malaria in Europe have been the mass migrations of people; soil disturbance by bombardments, floods, and the destruction of sanitary engineering works; a decrease in the number of livestock, resulting in the increased attraction to man of anophelines which are normally attracted to animals; the disruption of public-health services and the scarcity of drugs and larvicides. The disease has appeared sporadically in various countries from which it had practically disappeared, such as Austria, France, Ireland, Norway, Switzerland and the United Kingdom. Moreover, renewed outbreaks have occurred in endemic areas, and malaria has spread to regions where it was formerly unknown.

The displacement and transfer of populations, and the return to Europe of troops from malarious countries, were largely responsible for the spread of the infection and for an increase in its incidence, in the following ways :

— by bringing into malarious regions non-immunized persons arriving from regions free from malaria;

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[1] See *Chron. World Hlth Org.* 1948, 2, 278

— by bringing parasite-carriers into regions free from malaria, but in which anophelines capable of spreading the disease are to be found;

— by bringing into a malarious region persons suffering from malaria, carriers of parasitic strains differing from the local species and against which the indigenous population is not immunized.

Statistical data on malaria incidence among civilians during the war and in the post-war period make it possible to follow its development in the various countries of Europe. Such data must, however, be considered approximate, as many cases are not reported, especially in rural areas, even in countries where the notification of malaria is compulsory.

In Scandinavian countries, only Finland reported numerous cases of malaria, particularly among troops stationed in Karelia, the source of infection probably being the Russian troops at the front.

In the United Kingdom, in spite of the large number of hospitalized soldiers suffering from malaria, the disease has not spread.

In Belgium, where floods caused by the occupying authorities created conditions favourable for the breeding of anophelines, the disease, which had been dormant for years, did not reappear.

In the Netherlands, on the other hand, in the provinces of Friesland and North Holland where malaria was present before the war, there was a marked increase in the number of cases. Approximately 8,500 cases were reported in 1946, some of which were probably not indigenous.

In Germany, as a result of the return of soldiers and prisoners suffering from malaria, a few hundred indigenous cases were reported in various parts of the country, especially after the end of the war. In Berlin, 220 local cases had been reported up to July 1946. These cases can no doubt be attributed to *Anopheles messeae*, which now breeds among the ruins in the centre of the city. In Eastern Friesland, the only endemic focus of infection in Germany, malaria decreased gradually during the war, whereas the reverse occurred in the endemic foci in the Netherlands. The number of cases dropped from 327 in 1938 to six in 1945.

In Poland, which had been the scene of serious malaria epidemics after the first World War, from 250 to 300 cases only were reported annually between 1933 and 1939. But from 1940 onward, the number of cases gradually increased, reaching, in 1946, a total of 14,000 — which figure probably does not give a true picture of the situation — in endemic foci spread over most provinces, even in regions where the disease had never before been reported. A control campaign was inaugurated, and in 1947 the number of cases amounted to 60% of those reported in the previous year.

In Czechoslovakia, malaria — caused by *Plasmodium vivax* and *P. falciparum* — is present in a noticeable degree only in Slovakia, so that the disease again became an important problem on the re-constitution of the country.

In Hungary, the malaria morbidity-rate throughout the country, including temporarily annexed territories, increased between 1938 and 1944. From 1945 to 1947, new foci appeared in regions which up to then had been largely free from the disease. This country provides an obvious example of an increase in malaria due to the influx of infected persons into regions of anophelism free from malaria, and to the entry into malarious regions of persons carrying parasitic strains differing from the local varieties.

The countries of southern Europe are all malarious to a greater extent than the countries mentioned above.

In Italy, the number of cases of malaria — endemic and epidemic — increased from 55,000 in 1939 to 470,000 in 1945. The mortality-rate however, did not keep pace with these figures. This fact may be attributed to the greater efficacy of therapeutic measures. The decrease in the number of cases in 1946 follows the DDT campaign begun that year in many malarious regions of Italy.

In Spain and Portugal, an increase in the number of cases has been noted, which cannot be directly attributed to the war and the origin of which remains unexplained.

In Greece, where notification of cases is not compulsory, few data are available. Malaria incidence from 1941 to 1944 was approximately the same as for the years before antimalarial services were created in 1937. The disorganization of these services by the war, followed by famine, contributed to a fresh outbreak of the disease, which reached its peak in 1942. At the beginning of 1946, DDT was applied in a large part of the country and the morbidity-rate was reduced to the lowest figure yet achieved.

In Bulgaria, the malaria morbidity-rate decreased from 1942 onward. Approximately 150,000 cases were reported in 1946.

In Roumania, a decrease in the morbidity-rate, beginning in 1943, has also been noted. Following an extensive control campaign, the mortality-rate dropped in certain highly infested districts from 105 per 100,000 inhabitants in 1945 to 23 per 100,000 in 1947.

During the second World War, malaria spread over Yugoslavia, reaching a peak in 1941, when the disease appeared in regions which had been free up to that time. In 1945 and 1946, mass movements of populations caused epidemics in certain areas. Antimalarial services were reorganized in 1947, and the use of DDT was followed by a decrease in the morbidity-rate.

The various reports emanating from European countries, analysed by Dr. Pampana in his article, lead to the conclusion that renewed outbreaks of malaria after the second World War have been less serious than after the first World War. The application of DDT in numerous endemic regions, particularly in Italy and Greece, together with the use of new synthetic drugs, might explain, at least in part, this sequence of events. The success of vector-eradication campaigns carried out against *A. gambiae* in Brazil

and Egypt,[2] has shown that the complete eradication of a species of insect is possible, even from vast territories. Analogous experiments are at present being carried out in Sardinia and Cyprus. Measures which have been taken up to now, and the favourable results obtained, make it possible to foresee the day when Europe will be free from malaria.

[2] *Chron. World Hlth Org.* 1948, 2, 285

INFLUENZA IN EUROPE

The first indication that influenza had become unduly prevalent appeared in Sardinia in October when, in the course of a few days, about half of the island's population was attacked. By November, the disease had reached the mainland of Italy and the island of Sicily. By the end of that month, half of the population of Rome had been affected, while other towns, especially Venice, Verona, Milan, Pisa, Pescara, Palermo and Catania had been seriously involved. The clinical character of the disease was ordinarily mild — serious cases, sometimes proving fatal, being observed only in old people.

In December, the disease made its appearance in France. During the first week of January the eastern and northern provinces were mainly affected, but by the end of the second week practically all the country had become involved in an epidemic from which one-fifth of the population suffered. The disease was ordinarily of a mild variety, but provided, nevertheless, a certain number of serious, even fatal, cases, particularly among young children and old people.

On 7 January, WHO made a telegraphic inquiry of a majority of European countries as to the situation, and replies received between 8 and 18 January gave the following information :

Austria : several thousand cases, mainly in Vorarlberg and Tyrol

Greece and *Poland :* sporadic cases of a mild character

Switzerland : 13 cantons affected, particularly Basle-City, Geneva, Schaffhouse and Tessin

Denmark, *Finland*, *Norway*, *Sweden*, the *American Zone of Germany*, *Spain*, *Portugal*, *Ireland*, *Albania*, *Hungary* and *Turkey :* no epidemic, only a number of sporadic cases

United Kingdom : no epidemic prevalence reported anywhere, only a number of usual cases in London

Bulgaria : influenza in mild form since mid-December, attacking mostly young children and persons over 60; the disease seems to follow a fairly prolonged course

Netherlands : epidemic in the southern part of the country, but relatively infrequent in the north.

Action taken by WHO

Since the beginning of the epidemic, the special influenza laboratory of the Medical Research Council, Hampstead, London, acting as the World Influenza Centre of WHO, has been engaged in identifying the causal virus or viruses from throat-washings obtained from cases in Great Britain, France and Italy.

It may be recalled that plans for the establishment of a World Influenza Centre were laid down in September 1947.[1] The Interim Commission, aware of the danger of a new influenza epidemic, similar to the one which wrought havoc in 1919, recommended the establishment of a central laboratory to collect and distribute information on outbreaks of influenza epidemics, to collect and distribute pathological material, necessary for the identification of the type of virus and the preparation of corresponding vaccines, and to train laboratory workers from other countries. The proposed centre was established in 1948 and Dr. C. H. Andrewes assumed its direction.[2]

To facilitate identification of the type forms responsible for the present epidemic, WHO had asked that throat-washings or fresh sputum for testing for virus should be submitted for laboratory investigation, packed in ice or dry ice (CO_2), and dispatched by air or otherwise, so that they reach the laboratory within 24 hours of being obtained. Specimens sent by ordinary post were not considered worth testing. It was recommended that throat-washings be obtained by the patient gargling 15 ml. physiological saline solution and spitting this into a container, to which 5 ml. bacteriological broth should be immediately added and the whole put as quickly as possible in refrigeration.

Health administrations were requested to co-operate in this investigation by submitting for test appropriate samples to the World Influenza Centre, or to the nearest regional laboratory working in conjunction with it, the names and addresses of which were listed in the *Weekly Epidemiological Record*, 1949, **24**, 18.

Type of Virus incriminated

France. On 12 January, a telegraphic message from the WHO World Influenza Centre indicated that Dr. Lépine of the Institut Pasteur had identified virus A as the cause of half the current cases in France and had reported that the other half were due to a strain which seemed unrelated to either A or B. These findings were confirmed on 15 January in a telegram received from the French Ministry of Public Health.

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[1] *Chron. World Hlth Org.* 1947, **1**, 125
[2] *Ibid.* 1948, **2**, 44

Netherlands. On 12 January, WHO was informed by cable from the Hague that virus A had been definitely identified in the southern part on serological evidence by Prof. J. Mulder of the University of Leyden, although the sub-type was not clear. In a later report, Prof. Mulder stated that the Dutch virus appeared to be related to the 1947 A type, which caused an extensive epidemic in Sweden and lesser epidemics in Holland, the United Kingdom and the United States of America.

EASTERN MEDITERRANEAN CONFERENCE

The representatives of approximately twenty countries of the Eastern Mediterranean region will be meeting in Cairo on 7 February to set up a regional organization in that area, in accordance with the decision taken by the first World Health Assembly. It will be recalled that the Assembly made provision for the establishment of six regional organizations and delimited their respective zones.[1]

The Regional Organization for South-east Asia, comprising Afghanistan, Burma, Ceylon, India and Siam, was set up first, with headquarters in New Delhi, and started activity in the beginning of 1949.[2]

A special office for the health rehabilitation of European countries devastated by the war — an office which is not intended to form part of any scheme for regional organization — has just been opened in Geneva at the headquarters of WHO. Its purpose is to help those countries whose health problems are serious as a result of the war, and which lack drugs, medical supplies and personnel.[3]

The object of the Cairo Conference is to integrate the Sanitary Bureau at Alexandria[4] with WHO, and to establish an office for the Eastern Mediterranean which, according to the Constitution of WHO, will form the administrative body of the Regional Organization.

The Eastern Mediterranean region comprises Aden, British Somaliland, Cyprus, Egypt, Eritrea, Ethiopia, French Somaliland, Iran, Iraq, Lebanon, Pakistan, Palestine, Saudi Arabia, Syria, Transjordan, Tripolitania, Turkey and Yemen.[5] France and the United Kingdom have been invited to participate in the Conference to represent those territories whose external affairs they administer.

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[1] *Chron. World Hlth Org.* 1948, 2, 191

[2] *Ibid.* 1948, 2, 225

[3] *Ibid.* 1948, 2, 275

[4] For an account of the Bureau, see *Off. Rec. World Hlth Org.* 12, 65

[5] Greece, which originally appeared on the list of countries belonging to the Eastern Mediterranean, has requested that it be attached to the European Region.

SEROLOGY OF SYPHILIS

The Expert Committee on Venereal Infections has suggested that WHO might usefully seek to establish a uniform level of reactivity in serological tests for syphilis, as well as a repository for the resulting reference standard antigen. It was unanimously recognized that there was a pressing need for the correction of the many discrepancies arising, largely, from the use of tests in which the level of reactivity had been decided individually by the originator of each method. Moreover, no concerted effort has been made to decide upon a uniform level of sensitivity and to adjust the various test methods to that level. It is of great importance, moreover, that the level of reactivity determined upon should be the most suitable for the diagnosis of syphilis, while remaining, as far as possible, unaffected by reacting substances produced by diseases other than syphilis. Until this optimal level has been defined, discrepancies will continue to occur whenever several tests are employed.

The advent of cardiolipin-lecithin antigens has made possible the preparation of antigens of almost any desired degree of reactivity. Once the optimal level has been determined, an antigen designed as a reference standard can be prepared and made available for use by any laboratory or commercial concern wishing to manufacture antigens for a given test.

Studies on Serological Tests

The committee has also considered the studies carried out by WHO on serological test-performance in the principal laboratories in Ethiopia and Bulgaria. Similar test-performance evaluations will shortly be carried out in Poland, and, eventually, in several other countries. In this work WHO used the United States Public Health Service venereal-disease research laboratory in New York as an international serological reference centre. While furnishing guidance to the laboratories themselves, these studies also help to determine the effect of transportation on serum samples under various conditions. Experience of considerable value to national standardization is accumulating, and this is an important preliminary to the contemplated International Serological Laboratory Conference.[1]

The committee recommended that a sub-committee, of not more than 4 members, on serology and laboratory aspects, be established as soon as possible, and that a preliminary programme for the International Serological Laboratory Conference be drawn up at an early date for consideration by the committee.

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[1] *Chron. World Hlth Org.* 1948, 2, 20

Influence of Environmental Factors

Preliminary observations in certain countries have led to the belief that environmental factors may be responsible for a high percentage of positive serological findings in some population groups in which the disease is comparatively rare. Without more complete and precise knowledge of this phenomenon it may be difficult to determine the extent of syphilis in a given area, or the effectiveness of any control measures taken, and WHO experts consider that a thorough study of the problem is essential.

Only by means of large-scale clinical and laboratory investigation of representative population groups in different geographical areas could this study be attempted. Careful attention would have to be devoted to the relationship between positive serological findings and seasonal and climatic factors, diet and standard of living and the simultaneous existence of other infections.

Members of the expert committee were unanimous in recommending that WHO should undertake research on this question.

PENICILLIN IN VENEREAL DISEASES

Although penicillin is of vital importance for the treatment of diseases other than venereal infections, there are indications that, should it become freely available all over the world, by far the largest proportion of the drug would be consumed in the treatment of syphilis and gonorrhoea.

Ambulatory Treatment

High hopes were placed by the WHO Expert Committee on Venereal Infections on the potentialities of ambulatory treatment in venereal diseases. The committee examined the reasons for failure in the penicillin treatment of syphilis and gonorrhoea reported on several occasions in the medical press. Experience in the penicillin therapy of syphilis is now based on more than half a million cases in the United States alone, extending over a period of more than 5 years, but the fact was emphasized that much of the early work was performed with pharmaceutical preparations which were imperfect in quality and variable in unitage. Dosage schedules were tentative and below the minimum now considered necessary. Further, since this therapy frequently relied on injections given at short intervals over a period of time, mass treatment of syphilis by this method tended to be dependent on the number of hospital beds available, and upon the cost of hospitalization during the required period. Although in some countries, such as the Scandinavian countries and the United Kingdom, it may be possible to

keep a relatively large proportion of patients under this kind of treatment without hospitalization, the procedure required in early penicillin therapy was not suitable for ambulatory treatment.

Production and Availability

The WHO Secretariat submitted to the committee a summary of data from 71 countries, showing the very limited production of penicillin and the worldwide need for it. On the basis of this and other evidence, the committee was convinced that the limited availability of penicillin is the chief restricting factor in venereal-disease control in the world today, and considered itself justified in continuing to support WHO in its efforts to encourage production and ensure an equitable distribution to all countries, particularly those where penicillin is not now available.

Experiments have recently been carried out for the production of penicillin without the usual growth-media, which are often difficult to obtain in sufficient quantities, and using instead a substance which is generally available, and which contains similar growth-factors. It was suggested that WHO might well assume responsibility for the promotion on a wide scale of such processes, which promise to increase the production and availability of penicillin.

Funds have been supplied by WHO for a survey of the needs of UNRRA penicillin plants in certain European and Far Eastern countries, but no grant will be made from UNRRA residual funds for reconditioning these plants. The committee therefore recommended that other means of getting these plants into operation should be considered as soon as the contemplated survey had been carried out. It was suggested that, in the meantime, the matter might be studied by the United Nations Economic Commission for Europe, as industrial rehabilitation is one of its concerns.

Finally the committee felt that WHO should be prepared to advise on the quality and standard of the various types of penicillin : penicillin in oil and beeswax (POB), procaine penicillin in oil, procaine penicillin in oil with aluminium monostearate, or other types.

WHO Publications

New International Statistical Classification of Diseases and Causes of Death

Copies of the *Manual of the International Statistical Classification of Diseases, Injuries and Causes of Death* are now available. The first impression, of 20,000 copies, is already sold and a second is in the press.

This publication, which appears first in English, outlines the procedures to be followed in the compilation and publication of morbidity and mortality statistics, as adopted by the Sixth Decennial Revision Conference, held in Paris, April 1948. It is planned that there shall be editions in French and Spanish.

The *Manual* differs appreciably from the official documents issued after previous revision conferences in that it provides for the first time a single list for coding both diseases and causes of death; it will therefore meet the needs not only of vital statistics offices, but also of hospitals, clinics, social security administrations, and other agencies compiling morbidity statistics. An extensive *Tabular List of Inclusions* — i.e., a list of diagnostic terms defining the content of each category of the list — and an even more comprehensive *Alphabetical Index*, both of which are included in the *Manual*, will contribute considerably to the uniform assignment of diagnoses to the various titles of the classification.

Three shorter lists for tabulation of routine morbidity and mortality statistics represent a further innovation. The *Manual* also contains, as a new feature, an *International Form of Medical Certificate of Cause of Death*, and gives rules for classification which place upon the certifying physician the responsibility for indicating the underlying cause of death to be shown in primary tabulations.

Included in the *Manual* also are WHO Regulations No. 1 regarding nomenclature with respect to diseases and causes of death, which were adopted by the first World Health Assembly to ensure as far as possible the uniformity and comparability of statistics of diseases and causes of death. This international law, coming into force on 1 January 1950, regulates the various steps in the compilation and publication of morbidity and mortality data.

Unlike its predecessors, the new international *Manual* will be used as such, and not merely as a basis for the preparation of national manuals. Only countries unable to utilize the international version in any of the languages in which it is published will find it necessary to prepare corresponding national manuals.

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Volume 2

Alphabetical Index

International Digest of Health Legislation

The first number of the *International Digest of Health Legislation* has now been published in English and in French. It forms a successor to the first section of the *Bulletin mensuel de l'Office International d'Hygiène Publique*, the last number of which appeared in December 1946 on the transfer to WHO of the duties and functions of OIHP.

The *Digest* will consist of reprints and translations of, or extracts from, the texts of the most important laws and regulations dealing with public health and related subjects adopted in different countries. It is intended for all who are interested in the administrative and legislative aspects of public health.

This number contains the text of the following :

Australia (Western Australia)

Regulations : Registration of nurses
By-laws : Eating-houses

Belgium

Order : Control of sera, vaccines, etc.
Order : Milk trade
Decree : Private slaughter-houses

France

Order : Laboratory equipment
Decree : State Diploma in Child Welfare
Decree : Commission for the general supervision of training and probation periods established for the State Diploma in Child Welfare
Order : Exercise of the nursing profession (male and female nurses)
Order : Narcotic drugs
Order : Formulae of medicaments
Decree : Medical ethics
Decree : Consultative Commission on New Therapies
Decree : Regulations governing blood transfusion and resuscitation centres
Decree : Commission on Mental Hygiene
Decree : Regulations governing the exercise of the professions of medical masseur and gymnastics instructor and of chiropodist
Decree : Regulation of the profession of medical masseur and gymnastics instructor
Decree : Entrance examination for schools preparing for the State Diploma for Masseur-Kinesitherapists
Decree : Declaration of tularaemia
Decree : Sale of raw milk for human consumption
Decree : Serological examinations for the diagnosis of syphilis
Decree : Commission on the Therapeutic and Biological Uses of Radio-Isotopes
Decree : Internment, exhumation, cremation and transport of corpses
Decree : State Diploma for Social Workers of both sexes. State Diploma for Hospital Nurses of both sexes

Decree : Medical examination
Decree : Commission on Sanitary Questions
Decree : Commission for the Study of Sanitary Questions
Decree : Medical supervision for staffs of teaching and educational institutions
Decree : Title of specialists provided under Article 22 of the general schedule of professional registers

French Cameroons

Order : Medical surveillance

Gold Coast

Ordinance : Lunatic asylums

India (North-West Frontier Province)

Act : Vaccination

Indo-Chinese Federation

Order : Public health

Ireland

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Lebanon

Maritime Code (safeguarding of seamen's health)

Northern Rhodesia

Ordinance : Births and deaths registration

South West Africa

Regulations : Registration of medical practitioners

Southern Rhodesia

Regulations : Aviation hygiene

Sudan

Regulations : Quarantine

Tunisia

Order : Smallpox vaccination

Union of South Africa

Regulations : Registration of medical practitioners
Regulations : Health services
Regulations : Health services

United Kingdom (Scotland)

Regulations : School health

Epidemiological and Vital Statistics Report

The *Report* is bilingual, English and French, and is published monthly. Contents of the latest numbers are :

Vol. I, No. 15 (August, 1948) : An article on the present state of population growth, and tables showing birth-rates for certain countries and for large towns.

Vol. I, No. 16 (September, 1948) : Tables of statistics of cerebrospinal meningitis and poliomyelitis.

Vol. I, No. 17 (October, 1948) : Tables of statistics of whooping cough, diphtheria, measles and scarlet fever.

Notes and News

Fifty-eight Nations Members of WHO

By July 1948, 54 countries had ratified the Constitution of WHO, and had taken part as Member States in the first World Health Assembly. During the following months, three South American States, Chile, Argentina and Paraguay, deposited their instruments of ratification, bringing the number of Member States of the Organization to 57.

Paraguay is the tenth member of the Pan American Sanitary Organization to join WHO. This accession is a further step towards the integration of PASO with WHO. The Pan American Sanitary Organization will act as the regional organization of WHO in the American region, as soon as 14 of its Member States have become Members of the World Health Organization.[1]

Lebanon deposited instruments of ratification at Lake Success as of 19 January, and, as announced elsewhere in this issue, will be sending delegates to the WHO Regional Conference for the Eastern Mediterranean.[2] This brings the number of Member States of WHO to 58.

Periods of Validity of Immunization Certificates

The Section on Quarantine of the Expert Committee on International Epidemiology and Quarantine which met in Geneva on 18 November 1948 requested the WHO Secretariat to advise national health-administrations that the periods of validity of certificates of immunization against cholera, smallpox and yellow fever, as laid down in the texts of the International Sanitary Conventions of 1944, are to be interpreted as follows:

Certificate	*Period of validity, reckoned from the date of immunization*
Inoculation against cholera	7 days to 6 months
Vaccination against smallpox	14 days to 3 years
Inoculation against yellow fever	10 days to 4 years (except in the case of persons reinoculated within 4 years)

Venereal Diseases

Dr. José Amador Guevara (Costa Rica) has been appointed WHO Expert consultant in venereal diseases to the Philippine Government. Dr. Amador Guevara was a member of the medical teaching mission, sponsored jointly by WHO and the Unitarian Service Committee of America, which recently visited the Philippines at the request of the Government.[3]

Dr. Alain Spillmann (France) has spent one month in Italy as a WHO expert consultant, studying the venereal-disease situation and helping to establish demonstration programmes in several cities. Such a programme is already in operation in Naples with excellent results.

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[1] *Chron. World Hlth Org.* 1948, 2, 235

[2] See p. 13

[3] *Chron. World Hlth Org.* 1948, 2, 263

Czechoslovakia also has requested technical assistance from WHO in developing plans for the control of venereal disease. Dr. James Lade (USA) has been assigned to assist local authorities.

Fellowships in Venereal Diseases

The Expert Committee on Venereal Infections at its second session, held in October in Paris, recommended that fellowships for the study of venereal diseases be classified into two groups :

(*a*) for senior physicians and personnel : short-term travel grants, 3 to 6 months;

(*b*) for physicians, laboratory workers, public-health nurses or social workers : 3 months' to 1 year's training.

Conference on Penicillin Production

The temporary special office in Geneva for health rehabilitation in Europe [1] has called a conference for 17 February in Geneva, which will bring together technical experts from a number of countries where the penicillin plants supplied by UNRRA are located. Representatives have been invited from Byelorussia, Czechoslovakia, Poland, Ukraine and Yugoslavia, and specialists in penicillin production-methods from England and Denmark have been asked to attend. It is hoped that from this meeting more detailed information will emerge on the possibilities of using the former UNRRA plants as part of the general effort to make large amounts of penicillin available to those areas which are in most need of this drug.

WHO Representative for Palestine Relief

Dr. J. D. Cottrell, Medical Officer of WHO, has been appointed WHO representative for UN Palestine Refugee Relief. Dr. Cottrell, who comes from New Zealand, and has wide experience of medicine and of public-health administration, returned recently from Austria where he directed the WHO field mission. He was formerly attached to UNRRA.

Dr. Cottrell has stated that, according to the latest reports received in Geneva, the health conditions of the 700,000 refugees in Palestine and neighbouring States are such that energetic action is urgently necessary. Typhoid fever, dysentery and other intestinal diseases are causing havoc among them, and, in particular, immediate action against malaria is needed, as many refugees are at present living in highly malarious regions.

Recent and Forthcoming Meetings

24 January :	Expert Committee on Habit-forming Drugs, first session, Geneva
24-28 January :	Expert Committee on Maternal and Child Health, first session, Geneva
28-29 January :	WHO/UNESCO Executive Committee of the Organizing Committee for the Co-ordination of International Congresses of Medical Sciences Paris
7 February :	WHO Conference of Eastern Mediterranean Countries, Cairo
17 February :	Conference on UNRRA penicillin plants, Geneva
21 February :	WHO Executive Board, third session, Geneva
14-15 March :	Joint Committee on Health Policy, UNICEF/WHO, Geneva

[1] *Chron. World Hlth Org.* 1948, 2, 275

March (tentative) :	WHO Regional Committee for South-East Asia, second session, New Delhi
20 April :	Expert Committee on the Unification of Pharmacopoeias, fourth session, Geneva
27 April :	Sub-Committee on Fat-soluble Vitamins, first session, London
2 May (tentative) :	Expert Committee on Biological Standardization, third session, London
13 June :	Second World Health Assembly, Rome

PUBLICATIONS OF THE WORLD HEALTH ORGANIZATION *

WEEKLY EPIDEMIOLOGICAL RECORD

(Bilingual : English and French)

This publication, intended for national health-administrations and for health services at ports and frontiers, contains notifications concerning diseases qualified as " pestilential " in the International Sanitary Conventions, as well as other information about the application of these Conventions.

It is mainly intended for official use and is not for sale separately. It can, however, be obtained in conjunction with the *Epidemiological and Vital Statistics Report* (see below).

EPIDEMIOLOGICAL AND VITAL STATISTICS REPORT

(Bilingual : English and French)

The *Report* is published monthly and contains statistics on infectious diseases, mortality-rates, etc. The statistical information is supplemented by various articles and notes on epidemiological and demographic subjects.

Subscription for 1949	25/-	$5.00
Price per single copy	2/6	$0.50

Annual subscription, including the *Epidemiological and Vital Statistics Report* and the *Weekly Epidemiological Record*, for the use of libraries, medical schools, etc. £2 $8.00

OFFICIAL RECORDS OF THE WORLD HEALTH ORGANIZATION

(Separate editions in English and in French)

The fifteen volumes of the Official Records so far published mark the successive stages in the evolution of WHO. They comprise :

No. 1. Technical Preparatory Committee for the International Health Conference

—containing the minutes, with supporting documents, of the Paris meeting of March-April 1946, at which the form and scope of the future Oragnization were discussed and its Constitution tentatively drafted.

No. 2. International Health Conference

—proceedings of the Conference, held in New York in June-July 1946, which culminated in the signing of the WHO Constitution. The volume contains, besides the texts of the Constitution and other relevant Acts, a summary report on the Conference, minutes of the plenary meetings, and supporting material.

* All prices are post-free

No. 3. First session of the Interim Commission

No. 4. Second session of the Interim Commission

No. 5. Third session of the Interim Commission

No. 6. Fourth session of the Interim Commission

No. 7. Fifth session of the Interim Commission

— each containing minutes and supporting documents

No. 8. Reports of expert committees

(biological standardization; malaria; preparation of the sixth decennial revision of the International Lists of Diseases and Causes of Death; quarantine; revision of the pilgrimage clauses of the international sanitary conventions; tuberculosis; unification of pharmacopoeias; venereal diseases)
—as submitted to the Interim Commission.

No. 9. Report of the Interim Commission (Part I : Activities)

—the résumé of its work submitted by the Commission to the first World Health Assembly.

No. 10. Report of the Interim Commission (Part II : Provisional Agenda)

—the volume that constituted the agenda of the first World Health Assembly.

No. 11. Reports of expert committees, and other advisory bodies

(tuberculosis; biological standardization; plague and typhus; cholera; smallpox; international epidemic control; International Lists of Diseases and Causes of Death; plague; schistosomiasis; malaria; unification of pharmacopoeias)
—a sister volume to No. 8.

No. 12. Supplementary report of the Interim Commission

—a sequel to Nos. 9 and 10, which it completed.

No. 13. First World Health Assembly

—containing verbatim records of the plenary meetings, minutes and reports of the main committees, summary of decisions and relevant appendices.

No. 14. Reports of the Executive Board, first and second sessions

No. 15. Reports of expert committees

(tuberculosis; venereal diseases; unification of pharmacopoeias — as submitted to the second session of the Executive Board)

Forthcoming Numbers :

No. 16. Report of the Director-General to the second World Health Assembly

No. 17. Report of the Executive Board, third session

Price:

No. 13. First World Health Assembly	2/6	$0.50
Other numbers, per copy	1/3	$0.25

Vol. 1, No. 2

BULLETIN OF THE WORLD HEALTH ORGANIZATION

(Separate editions in English and in French)

This number includes, in addition to two reports of expert committees, the following signed articles:

Malaria control by residual indoor spraying with DDT, by E. J. PAMPANA

Trials of causal prophylaxis of malaria with paludrine, by M. CIUCA, L. BALLIF and M. CHELARESCO

Preliminary note on therapy of malaria with paludrine, by M. CIUCA, A. SOFLETE, P. CONSTANTINESCO and E. TERITEANU

Species-eradication: the eradication of *Anopheles gambiae* from Upper Egypt 1942-1945, by Sir Aly Tewfik SHOUSHA, Pasha

Cholera epidemic in Egypt (1947): a preliminary report, by Sir Aly Tewfik SHOUSHA, Pasha

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